

DATE OF REQUEST: \_\_\_\_\_

**KENTUCKY WIC PROGRAM DRUG STORE APPLICATION**

**Please Print unless otherwise indicated.**

**ALL QUESTIONS ON THE APPLICATION MUST BE PROPERLY AND FULLY COMPLETED. PLEASE REVIEW THE WIC INFORMATION MANUAL FOR PROSPECTIVE DRUG STORES FOR INSTRUCTIONS ON COMPLETING THIS FORM.**

1. STORE NAME \_\_\_\_\_

**2. PHYSICAL STORE ADDRESS:**

STREET # \_\_\_\_\_ STREET NAME \_\_\_\_\_

CITY \_\_\_\_\_ COUNTY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

**3. MAILING ADDRESS (Do not complete if mail can be delivered to the store's physical location.):**

STREET # \_\_\_\_\_ STREET NAME \_\_\_\_\_

RURAL ROUTE NUMBER/P.O. BOX \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

4. **STORE TELEPHONE NUMBER:** ( \_\_\_\_\_ )  
Area Code Number

5. **TYPE OF OWNERSHIP (Check One):** ☐ Single Owner ☐ Partnership ☐ Corporation

**6. OWNERSHIP INFORMATION:**

**A. CORPORATION NAME AND ADDRESS (For any business that is incorporated):**

CONTACT PERSON: \_\_\_\_\_ , \_\_\_\_\_ TITLE: \_\_\_\_\_  
Last Name First Name

BUSINESS NAME: \_\_\_\_\_

STREET#/NAME: \_\_\_\_\_

P.O. BOX: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

TELEPHONE NUMBER: ( \_\_\_\_\_ )  
Area Code Number

**Privacy Act Statement:** The collection of the Social Security Number (SSN) is authorized by

Section 2018 of Title 7, US Code and will be used to determine whether a store qualifies to participate in the WIC Program, to monitor compliance with Program regulations; and for Program management. The provision of the SSN's will be available only to officers and employees whose duties or responsibilities require access for the administration or enforcement of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program) and the Food Stamp Act.

**B. OWNER(S) NAME(S), SOCIAL SECURITY NUMBER(S) AND TELEPHONE NUMBER(S):**

(Complete for single owners, partnerships, principal shareholders of private corporations, corporate officers, etc. Include spouse, if spouse is considered an owner. Attach a listing if more convenient.)

Name \_\_\_\_\_ SSN \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last Name First Name

Name \_\_\_\_\_ SSN \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last Name First Name

Name \_\_\_\_\_ SSN \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last Name First Name

Name \_\_\_\_\_ SSN \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last Name First Name

7. **MANAGER (if different from Owner):** \_\_\_\_\_  
Last Name First Name Social Security Number

8. When did (or will) the store open for business under the applying ownership?     
Month Day Year

9. How long has this store been in business? \_\_\_\_\_

Was this store previously operated under another name or owner? ☐Yes ☐No

If yes, indicate store name and owner of store:

\_\_\_\_\_  
Name of Store Owner

Was the store ever on the WIC Program? ☐Yes ☐No

10. Are you (applicant) related to the previous owner? ☐Yes ☐No

If yes, what is the relationship: \_\_\_\_\_

11. Have you (Applicant) ever previously participated in the WIC Program? ☐ Yes ☐ No

If yes, specify the date, the previous authorized WIC number (if known) and the store name (attach a list, if necessary):

Date: \_\_\_\_\_ Previous WIC Number: \_\_\_\_\_ Name of Store: \_\_\_\_\_

12. Including this store, have you (Applicant), the corporation or the manager ever owned, managed or been an employee of a firm which was disqualified or terminated from the WIC Program? ☐Yes ☐No

**If yes**, specify the date, the reason and identify the person(s) or corporation, store name and location involved.

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

\_Name of Store: \_\_\_\_\_

\_Person(s)/Corporation: \_\_\_\_\_

Address: \_\_\_\_\_

13. Do you (applicant) own or manage any other grocery or drug stores that are currently contracted with WIC? ☐ Yes ☐ No

**If yes**, list the name and address of the store(s). Attach a list, if necessary.

Name of Store \_\_\_\_\_

Address: \_\_\_\_\_

14. a. Are you authorized to accept Food Stamps? ☐ Yes ☐ No

If yes, Food Stamp Authorization Number: \_\_\_\_\_

- b. Are you a Medicaid provider? ☐ Yes ☐ No

If yes, Medicaid Provider Number: \_\_\_\_\_

15. Including this store, have you (Applicant, the corporation or manager) ever owned or managed a firm which violated the Food Stamp regulations, received a warning letter or was withdrawn, disqualified, assessed a civil money penalty or fined? ☐ Yes ☐ No

**If yes**, specify the date, the reason, and identify the person(s) or corporation, the store name and location involved.

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of Store: \_\_\_\_\_

Person(s)/Corporation: \_\_\_\_\_

Address: \_\_\_\_\_

16. Has the Owner, corporation or manager ever had a license denied, withdrawn, suspended or been fined for license violations (i.e., business or health licenses)? ☐ Yes ☐ No

**If yes**, list the type of license, the reason for and date of denial, fine, suspension, withdrawal or disqualification.

Type of License: \_\_\_\_\_ Reason: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

17. BUSINESS ETHICS: Are any of the following now charged with or have they ever been convicted of or had a civil judgment for fraud; antitrust violation; embezzlement, theft or forgery; bribery; falsification or destruction of records; making false statements or claims; receiving stolen property; or obstruction of justice: 1) any partner, 2) owner, 3) any officer, 4) the corporate entity, 5) the manager, or 6) any stockholder who has a substantial role in the operation of the store? **If yes**, attach a written explanation, giving the name of the person(s) charged or convicted and their relationship to the owner, partner or corporate entity, and their current or past position, if any, in the store or corporation; the court and court docket number, the crime(s) and date(s) committed; the penalty and time served, and any other relevant information.

18. Indicate the number of cash registers: \_\_\_\_\_

Do any of these cash registers have optical scanners?

☐ Yes ☐ No

19. IS THIS STORE OPEN YEAR-ROUND? ☐ Yes ☐ No

If NO, check the months when the store is OPEN:

<input type="checkbox"/> January	<input type="checkbox"/> April	<input type="checkbox"/> July	<input type="checkbox"/> October
<input type="checkbox"/> February	<input type="checkbox"/> May	<input type="checkbox"/> August	<input type="checkbox"/> November
<input type="checkbox"/> March	<input type="checkbox"/> June	<input type="checkbox"/> September	<input type="checkbox"/> December

20. HOURS OF BUSINESS:

Monday	___ A.M.	to	___ P.M.
Tuesday	___ A.M.	to	___ P.M.
Wednesday	___ A.M.	to	___ P.M.
Thursday	___ A.M.	to	___ P.M.
Friday	___ A.M.	to	___ P.M.
Saturday	___ A.M.	to	___ P.M.
Sunday	___ A.M.	to	___ P.M.

21. List the bank of deposit that will be used for WIC food instruments and the complete address of the bank:

**Bank** \_\_\_\_\_  
Branch Name \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

22. Provide directions to the store from the Health Department in the county where the store is located (Provide highway numbers rather than stating 'Route 1, etc.').

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. Is the store name visible on the outside of the store? ☐ Yes ☐ No

Indicate name on sign or store front if different than name on the front of this application:

\_\_\_\_\_

24. Can you (applicant) supply all of the formulas listed on Attachment A to the Drug Store Vendor Agreement within 48 hours of verbal request? ☐ Yes ☐ No

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION SUPPLIED BY ME ON THIS APPLICATION AND THE ATTACHED PRICE LIST IS CORRECT. IF IT IS DETERMINED THAT THE INFORMATION SUPPLIED IS NOT CORRECT OR THAT, IN REVIEW OF THE INFORMATION SUPPLIED, THE STATE AGENCY FINDS THAT MY STORE DOES NOT MEET THE CRITERIA TO BE A WIC VENDOR, MY STORE WILL NOT BE APPROVED FOR A CONTRACT. I UNDERSTAND THAT, SHOULD MY STORE BE ACCEPTED FOR A WIC CONTRACT, I WILL BE BOUND BY WIC PROGRAM REGULATIONS AND POLICIES. **I UNDERSTAND THAT THIS IS ONLY A REQUEST FOR PARTICIPATION AND DOES NOT CONSTITUTE A CONTRACT AND I WILL NOT ACCEPT WIC FOOD INSTRUMENTS UNTIL I HAVE RECEIVED AN APPROVED WIC PROGRAM AGREEMENT AND AN AUTHORIZED WIC VENDOR STAMP.** THIS APPLICATION WILL BE A PERMANENT PART OF MY FILE.

\_\_\_\_\_  
AUTHORIZED SIGNATURE (**Applicant OR  
CORPORATE OFFICER ONLY**)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TITLE

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## LOCAL AGENCY USE ONLY

The following information must be obtained during an on-site visit. The on-site visit cannot be performed until the applicant has actually taken possession of the store and the property transfer has been completed.

1. Review Drug Store's SRP listing(s). (Does/Do) the SRP listing(s) have an extensive list of formula?  
☐ Yes ☐ No
2. Verify the Price List with the shelf or display case prices, if applicable.
3. Is this store primarily a drug store? ☐ Yes ☐ No If no, then explain: \_\_\_\_\_
4. Warn the applicant that he/she is not an Authorized WIC Vendor and cannot accept food instruments until the authorized stamp is obtained and training has been completed.
5. Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I CERTIFY THAT I HAVE VISITED THIS DRUG STORE AND FIND IT (☐ ELIGIBLE / ☐ NOT ELIGIBLE) BASED UPON THE CRITERIA FOR SELECTION OF VENDORS AND THE VENDOR AGREEMENT. IF THIS VENDOR IS NOT ELIGIBLE, PLEASE DOCUMENT WHY:

SIGNATURE OF LOCAL AGENCY \_\_\_\_\_ DATE: \_\_\_\_\_

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## STATE AGENCY USE ONLY

1. Date Food Stamp information verified: \_\_\_\_\_ Food Stamp Number: \_\_\_\_\_  
Date Medicaid Provider Number verified: \_\_\_\_\_ Medicaid Provider Number: \_\_\_\_\_
2. Does the drug store meet the Criteria? ☐ Yes ☐ No  
If no, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Recommended for approval? ☐ Yes ☐ No
4. Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Signature \_\_\_\_\_ Date \_\_\_\_\_